PBM Complaint

Request for Assistance

Attn: **Tracking ID:**

State Use Only

Alabama Department of Insurance

Insurance Consumer Services Division

201 Monroe Street, Suite 502 | Montgomery, AL 36104
(334) 241-4141 phone | (334) 956-7932 fax

(PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

Section I

Before you file a request for assistance with the Alabama Department of Insurance, ***you should first file an appeal with the Pharmacy Benefit Manager (PBM)/Insurance Company***. If you do not receive a satisfactory response, then complete this form, attach copies of the appeal denial and any important correspondence and/or documentation that relates to your request for assistance. **Mail to the address shown above**.

Pharmacy Name	Pharmacist Contact	Individual Complainant (if individual filing)
Address	Work Phone	Address
City, State, Zip	Cell	City, State, Zip
Email	Email	Email Phone

Section II

Provide a Spreadsheet if Multiple Individual Claimants Involved in Your Denied Appeal.

1. Complete name of Insurance Company: _____
2. **Name of Pharmacy Benefit Manager** (Respondent): _____
3. Name of Insured (Individual filing): _____ Name of Employer: _____
   a. Policy # _____ b. Group # _____ c. Claim # _____
   d. Rx # _____ e. Date Filled: _____ f. Date Claim Paid: _____
4. Have you reported this to any other governmental agency? **(Check One)** ☐ Yes ☐ No
   If yes, please complete the following: a. Name of Agency: _____
   b. File #, if known: _____
5. Are you represented by legal counsel? **(Check One)** ☐ Yes ☐ No
   If yes name of Attorney: _____
6. Does your complaint involve a **Self-Funded Health Benefit Plan** (ERISA)? **(Check One)** ☐ Yes ☐ No

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Section III

7. Describe your PBM Problem in Detail (use additional paper, if needed):

   - Provide separate documentation for each type of problem, *i.e., Clawbacks, Gag Clauses, Mail-order Pharmacies, Pharmacy/Pharmacist of Choice, PBM Affiliates, Steering*, *etc.*
   - Provide copies of the PBM Appeal Denial and appeal related documents.

What do you consider to be a fair resolution?

To the best of my knowledge, the information provided is true and accurate. I understand that a copy of this Request for Assistance and the attached information may be provided to the PBM or Insurance Company complained against.

X _____ _____

Pharmacy Representative Signature | Date

X _____ _____

Individual Complainant Signature (if filing individually) | Date